PATIENT INFORMATION (CONFIDENTIAL)

NAME_____SS#_____DATE_____
FIRST MI LAST
ADDRESS_____CITY/STATE_____ZIP_____
HOME PHONE_____ CELL PHONE_____ Email_____
BIRTHDATE_____ □ MINOR □ SINGLE □ MARRIED □ DIVORCED □WIDOWED SEX: □M □F
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER_____Phone_____
PERSON TO CONTACT IN CASE OF AN EMERGENCY_____ PHONE_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____ SS#_____
RELATIONSHIP TO PATIENT_____ DRIVER LICENSE#_____ BIRTHDATE_____
ADDRESS_____ CITY/STATE_____ ZIP_____
EMPLOYER_____ WORK PHONE_____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____
BIRTHDATE_____ SS#_____
INSURANCE COMPANY_____ GROUP_____ ID#_____
ADDRESS_____ CITY/STATE_____ ZIP_____
PHONE_____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____
BIRTHDATE_____ SS#_____
INSURANCE COMPANY_____GROUP_____ ID#_____
ADDRESS_____ CITY/STATE_____ ZIP_____
PHONE _____

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DENTIST OF BENEFITS DUE FOR MY SERVICES RENDERED.

I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I AGREE IF MY ACCOUNT IS NOT PAID IN FULL AT TIME OF SERVICE, I AM LIABLE FOR ANY AND ALL REASONABLE COLLECTION/ATTORNEY FEES IF APPLICABLE. A finance charge of 1-1/2% per month, which is an annual rate of 18% is charged on all past due accounts.

THE PARENT OR GUARDIAN THAT BRINGS IN AND SIGNS FOR A MINOR CHILD IS THE PARENT OR GUARDIAN RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.

SIGNATURE OF PATIENT OR PARENT/ GUARDIAN IF MINOR DATE

Referral Information

Whom may we thank for referring you to our practice? □Another Patient Friend Relative

Dental Office Insurance Newspaper Website Radio Google □ Other_____

Name of person or office referring you to our practice:_____